



Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: GULF COAST MEDICAL EVALUATIONS 1805 NORTHERN DRIVE LEAGUE CITY, TX 77573	MFDR Tracking #: M4-09-A457-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #: TEXAS MUTUAL INSURANCE CO Box #: 54	Date of Injury:
	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

The Requestor did not submit a position statement in accordance with rule §133.307. The following is taken from the DWC-60 table of disputed services. "Pre authorization is not required."

Amount in Dispute: \$4,428.67

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The following is the carrier's statement with respect to this dispute. 1. The requestor provided EMG/NCV testing on 4/22/2009. 2. Texas Mutual declined to issue payment for the treatment rendered due to lack of preauthorization. 3. The requestor argues that the initial EMG/NCV testing is not subject to preauthorization per rule 134.600(p)(8)(A). 4. The same rule 134.600 at (p)(12) "qualifies" the exemption at (p)(8) when it states that non-emergency health care requiring preauthorization includes those treatments and services that exceed or are not addressed by the Commissioner's adopted treatment guidelines or protocols. 5. Texas Mutual agrees that DWC Rule 134.600 at (p)(8)(A) does not apply to the requestor billing. However, 134.600(p)(12) identifies that those treatment and services that exceed or are not addressed by the Commissioner's adopted treatment guideline or protocols require preauthorization. 6. As such, please note preauthorization was requested for the EMG/NCV testing on 3/30/09 which was denied per physician advisor on 4/1/09. 7. The service billed exceeds the treatment/services indicated in Rule 137.100 (Treatment Guidelines) effective 5/1/07 and requires preauthorization in accordance with Rule 134.600. Please refer to the Disability Management Rules, Chapter 137 on the DWC website to determine if additional treatment requires preauthorization to prevent denial of future treatment/services."

PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
4/22/09	95900	N/A	\$366.00	\$0.00
4/22/09	95903	N/A	\$1,497.28	\$0.00
4/22/09	95904	N/A	\$1,495.00	\$0.00
4/22/09	95934	N/A	\$200.20	\$0.00
4/22/09	95864	N/A	\$520.19	\$0.00
4/22/09	99244	N/A	\$200.00	\$0.00
4/22/09	99358	N/A	\$150.00	\$0.00
Total Due:				\$0.00

PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 of the Texas Workers' Compensation Act, and pursuant to all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Tex. Admin. Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Tex. Admin. Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
3. 28 Tex. Admin. Code §134.600 sets out the guidelines for preauthorization, concurrent review, and voluntary certification of health care.
4. 28 Tex. Admin. Code §134.203 sets out the medical fee guidelines for professional services rendered on or after March 1, 2008.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated 6/4/2009

- CAC-39 – Services denied at the time authorization/pre-certification was requested.
- CAC-47 – This (these) diagnosis (ES) is (are) not covered, missing or invalid.
- CAC-97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- 217 – The value of this procedure is included in the value of another procedure performed on this date.
- 246 – The treatment/service has been determined to be unrelated to the extent of injury. Final adjudication has not taken place.
- 275 – The health care provider requested preauthorization. However, the insurance carrier denied approval (according to chapter 134)

Explanation of benefits dated 6/26/2009

- CAC-W4 – No additional reimbursement allowed after review of appeal/reconsideration.
- CAC-39 – Services denied at the time authorization/pre-certification was requested.
- CAC-47 – This (these) diagnosis (ES) is (are) not covered, missing, or are invalid.
- CAC-97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- 217 – The value of this procedure is included in the value of another procedure performed on this date.
- 246 – The treatment/service has been determined to be unrelated to the extent of injury. Final adjudication has not taken place.
- 275 – The health care provider requested preauthorization. However, the insurance carrier denied approval
- 891 – The insurance company is reducing or denying payment after reconsideration.

Issues

1. Are there unresolved extent of injury issues associated with the disputed charges?
2. Did the disputed services require pre-authorization?
3. Does the requestor's submitted medical record support the disputed charges and did the requestor submit the medical bill for the disputed services in accordance with 28 Tex. Admin. Code §133.20?
4. Is the requestor entitled to reimbursement?

Findings

1. The requestor submitted diagnosis codes 722.10 (lumbar intervertebral disc without myelopathy), 723.4 (cervical radiculitis and 724.4 (lumbar radiculitis). The insurance carrier denied all of the disputed charges with reason code "246" (The treatment/service has been determined to be unrelated to the extent of injury. Final adjudication has not taken place). A benefit dispute agreement signed on 6/4/09 states in part..."the parties agree the compensable injury is a producing cause of cervical sprain/strain, lumbar sprain/strain, disc bulge @ L4/5, lumbar osteophytes & disc degeneration with spondylosis & facet joint arthropathy at L5-S1, lumbar radiculopathy, severe hypertrophic osteophytes at C5-6, and cervical radiculopathy". Therefore, the carrier's denial of "246" is not supported.
2. The requestor billed CPT codes 95900-59, 95903, 95904, 95934, 95864, 99244 and 99358. The insurance carrier also denied these disputed codes with reason codes "CAC-39" (Services denied at the time authorization/pre-certification was requested) and "275" (The health care provider requested preauthorization. However, the insurance carrier denied approval). The requestor submitted a copy of a referral request to the insurance carrier for diagnostic testing for initial nerve conduction study and EMG. Neither the requestor nor the insurance carrier submitted a copy

of the insurance carrier's determination of the requested services. The insurance carrier submitted a copy of a precertification request by another provider, Dr. William High dated 3/30/2009 for CPT codes 95903, 95864, 95900, 95904 & 95934. The insurance carrier also submitted a copy of the utilization review decision dated 4/1/2009 for the requested CPT codes 95864, 95900, 95904, 95934 and 95903 which states they are **non-certified**. Under rule §134.600(p)(8)(A) Non-emergency health care requiring preauthorization includes: unless otherwise specified in this subsection, a repeat individual diagnostic study: with a reimbursement rate of greater than \$350 as established in the current Medical Fee Guideline. The carrier did not submit any supporting documentation that the services in dispute are for a **repeat** diagnostic study requiring preauthorization. Therefore, the carrier's denial of "CAC-39" and "275" is not supported.

3. The insurance carrier also denied CPT code 99358 (prolonged evaluation and management service not involving direct (face-to face) care that is beyond the usual service in either the inpatient or outpatient setting; used to report a total duration of prolonged service of 30 to 60 minutes) with reason codes "CAC-97" (The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated) and "217" (The value of this procedure is included in the value of another procedure performed on this date. Medicare lists this code with a status "B" indicator which means "payment for covered services are always bundled into payment for other services not specified." Review of the requestor's medical documentation submitted does not support the description of CPT code 99358. In addition, the submitted documentation supports that Demetris A. Green, MD signed the medical record indicating he rendered the services. Review of the submitted bill supports that Wayne Parks, DC rendered the services. Under rule §133.20(e)(2) A medical bill must be submitted: in the name of the licensed health care provider that provided the health care. Therefore, reimbursement to the requestor for the disputed CPT codes is not recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has failed to establish that reimbursement is due. As a result, the amount ordered is \$0.00.

PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Medical Fee Dispute Resolution Officer

3/31/11

Date

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Tex. Admin. Code §148.3(c).

Under Texas Labor Code § 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.